SECTION 7
BENEFITS & LIMITATIONS

Office Visit Limitations

An office visit includes, but is not limited to, the following:

- Oral examination of the recipient for symptoms or indications of a dental condition requiring treatment;
- Establishment of the written recipient record;
- Surgical gloves, drapes, tongue depressors, swabs, gauze, medications, administration of injection(s) and any other items or supplies considered to be routine to the dentist's private practice; and
- Local anesthesia.

Office visits are limited to one visit per recipient per provider on any given day and may not be billed on the same date of service as another office or outpatient visit, dental screen, subsequent hospital visit, consultation or nursing home visit. An office visit may be billed on the same date of service as a hospital admission.

Procedure codes 99201-99332 cannot be billed on the same date of service as procedure codes D0120-D0170 and D9310-D9440.

"New Recipient" office visits are limited to one per provider for each recipient when dental services have not been received in the past two years.

Billing for an office visit is expected *only* for the first session in a series of treatments.

Providers cannot bill a recipient for missed/broken appointments, nor can the Division of Medical Services (DMS) reimburse providers for missed/broken appointments.

Preventative

Prophylaxis of either the upper or lower arch or both arches is covered once in a six-month period. ***If a prophylaxis is required more often than every six months, a provider may bill under procedure code D9999 and attach office notes to the claim form explaining the medical necessity***. Prophylaxis must include scaling and polishing of teeth unless scaling is not required for the individual (usually a child) based on the condition at the time of the appointment. The recipient's record must document scaling was not required during the visit.

D1110 – Ages 13-125
D1120 – Ages 0-12

Fluoride treatment is limited to one application of stannous fluoride or acid-phosphate fluoride in six-month intervals. Each allowable fluoride treatment must include both the upper and lower arch. Fluoride treatments are covered for recipients under the age of 21.

D1201 – Includes the prophylaxis
D1203 – Prophylaxis not included

Fluoride treatments for recipients 21 and over, D1204, is limited to the following criteria:

- Recipients with rampant or severe caries (decay);
- Recipients who are undergoing radiation therapy to the head and neck;
- Recipients with diminished salivary flow;
- Mentally retarded individuals who cannot perform their own hygiene maintenance; or
- Recipients with cemental or root surface caries secondary to gingival recession.

Sodium fluoride series treatments are *not* covered.

Dental sealants are covered for recipients age 5 through 20. Sealants may be applied only on healthy first and second permanent molars which have not had the occlusal surface restored. Valid tooth numbers are 2, 3, 14, 15, 18, 19, 30 and 31. Payment for each tooth is a once in a lifetime fee. No payment is made for sealants applied to third molars.

Periodontal Scaling and Root Planing – D4341

Procedure code D4341 requires an approved prior authorization (PA). Along with the PA request, providers must submit a pretreatment x-ray (a full mouth survey taken within the last 12 months) and a periodontal chart. The following guidelines are used to determine medical necessity for approval of the PA request. Approval, if given, is per quadrant:

- Verifiable signs of early or moderate chronic periodontia;
- Records must show two or more sites in the quadrant being treated with;
    1) probing depths of 5mm or greater; ***and***
    2) early to moderate bone loss, ***or***
    3) radiographic evidence of subginvgival calculus.

Definition of bone loss:

- Early bone loss is cratering, or horizontal or vertical loss.
- Moderate bone loss is notable bone loss with 50% of the root remaining in the bone.

Restorations

- The same restoration on the same tooth in less than a six-moth period is not allowed.
- Amalgam restorations include polishing, local anesthesia, liner and treatment base.
- Resin restorations include local anesthesia, liner and treatment base.
- When billing for any of the amalgam, composite or resin restorations, the tooth number and tooth surface code(s) must be entered on the claim.
- Amalgam and resin restorations on posterior teeth are covered; resin restorations are covered on *anterior* teeth.

Crowns

- Prefabricated stainless steel crowns (D2930 and D2931) and prefabricated stainless steel crowns with resin window (D2933) for primary and permanent teeth are covered for recipients of all ages; replacement within six months is not covered.
- Prefabricated resin crowns are covered for recipients of all ages for *anterior* teeth only; replacement within six months is not covered.
- The fee for fixed prefabricated crown of chrome, stainless steel, resin, stainless steel with resin window or polycarbonate includes all prior preparations.
- Porcelain crowns are covered for recipients under the age of 21 on a prior authorized basis.

Extractions

- Procedure code D7140 is the appropriate code for all non-surgical extractions of erupted teeth, permanent and primary. The appropriate tooth number must be shown on the claim.
- Surgical removal of erupted teeth, D7210, is covered for permanent teeth only.
- The surgical removal of impacted teeth, D7220-D7241, is a covered service. A paper claim must be submitted for the removal of impacted teeth other than third molars and must include pre-treatment x-rays.
- The surgical removal of residual tooth roots (cutting procedure), D2750, is covered but cannot be billed on the same date of service as an extraction of the same tooth. Pre-treatment x-rays and office notes or operative report must be sent with the claim.
- Extraction fees for routine and impacted teeth include the fee for local anesthesia and post-operative treatment.

Dental Services/Care for Adults with a Limited Benefit Package

The following procedure code lists apply to Medicaid eligible adult recipients receiving a limited benefit package as a result of Senate Bill 539.

Procedure Code List "A"

The following codes are for services related to trauma or a medical condition.

10060	15261	21070*	21242	21400*	40500
10061	17000	21079	21243	21401*	40510
10120	17280	21080	21244	21406	40520
10121	17281	21081	21245	21407	40530
11044	17282	21082	21246	21408	40650
11100	17283	21083	21247	21421	40800
11101	20000	21084	21248	21422	40801
11440	20005	21085	21249	21423	40804
11441	20200	21086	21255	21431	40805
11442	20205	21087	21256	21432	40806
11443	20206	21088	21270	21433	40808
11444	20220	21089	21275	21435	40810
11446	20225	21120	21295	21436	40812
11640	20240	21121	21296	21440	40814
11641	20245	21122	21299	21445	40816
11642	20520	21123	21300	21450	40818
11643	20525	21125	21310	21451	40819
11644	20605	21127	21315	21452	40820
11646	20650	21141	21320	21453	40830
12011	20670	21142	21325	21454	40831
12013	20680	21143	21330	21461	40840
12014	20690	21145	21335	21462	40842
12015	20692	21146	21336	21465	40843
12051	20693	21147	21337	21470	40844
12052	20694	21150	21338	21480	40845
12053	20900	21151	21339	21485	40899
13131	20902	21154	21340	21490	41000
13132	20910	21155	21343	21493	41005
13133	20926	21159	21344	21494	41006
13150	21010*	21160	21345	21495	41007
13151	21015	21193	21346	21497	41008
13152	21025	21194	21347	21499	41009
13153	21026	21195	21348	29800	41010
14040	21029	21196	21355	29804	41015
14041	21030	21198	21356	30580	41016
14060	21031	21206	21360	30600	41017
14061	21032	21208	21365	31020*	41018
14300	21034	21209	21366	31030*	41100
15000	21040	21210	21385	31032*	41105
15120	21044	21215	21386	31600	41108
15240	21045	21230	21387	31603	41110
15241	21050*	21235	21390	31605	41112
15260	21060*	21240*	21395	40490	41113

Procedure Code List “A” (continued).

41115	42260	64736	99332	D5999	D7670
41116	42280	64738	99342	D6010	D7671
41120	42281	64740	99343	D6040	D7680
41130	42299	64795	D0140	D6050	D7710
41150	42300	99050	D0150	D6090	D7720
41153	42305	99058	D0160	D6095	D7730
41250	42310	99201	D0170	D6100	D7740
41251	42320	99202	D0210	D7260	D7750
41252	42325	99203	D0220	D7261	D7760
41500	42326	99204	D0230	D7270	D7770
41510	42330	99205	D0240	D7285	D7771
41520	42335	99211	D0250	D7286	D7780
41599	42340	99212	D0260	D7340	D7810
41800	42400	99213	D0270	D7350	D7820
41805	42405	99214	D0272	D7410	D7830
41806	42408	99215	D0274	D7411	D7840
41821	42409	99221	D0277	D7412	D7850
41822	42410	99222	D0290	D7413	D7860
41825	42415	99223	D0310	D7414	D7865
41826	42420	99231	D0330	D7415	D7870
41827	42425	99232	D4240	D7440	D7871
41828	42426	99233	D4241	D7441	D7872
41899	42440	99241	D4341	D7450	D7873
42000	42450	99242	D4342	D7451	D7874
42100	42500	99244	D4920	D7460	D7875
42104	42505	99245	D5913	D7461	D7876
42106	42507	99251	D5914	D7471	D7877
42107	42508	99252	D5919	D7472	D7880
42120	42509	99261	D5922	D7473	D7910
42140	42510	99262	D5926	D7485	D7911
42145	42550	99281	D5927	D7490	D7912
42160	42600	99282	D5932	D7510	D7920
42180	42650	99283	D5934	D7520	D7940
42182	42660	99284	D5935	D7530	D7941
42200	42665	99301	D5936	D7540	D7943
42205	42699	99302	D5952	D7550	D7944
42210	42700	99303	D5953	D7560	D7945
42215	42720	99311	D5954	D7610	D7946
42220	42725	99312	D5955	D7620	D7947
42225	42800	99313	D5958	D7630	D7948
42226	64600	99321	D5959	D7640	D7949
42227	64732	99322	D5960	D7650	D7950
42235	64734	99331	D5988	D7660	D7953

Procedure Code List "A" (continued)

D7955	D7980	D7991	D9212	D9242	D9440
D7960	D7981	D7995	D9220	D9248	D9951
D7970	D7982	D7996	D9221	D9310	41114
D7971	D7983	D7997	D9230	D9410	
D7972	D7990	D7999	D9241	D9420	

*These procedures can be performed bilaterally and billed with the "50" modifier.

Procedure Code List "B"

The following codes are considered support codes and are only billable in conjunction with a trauma or medical code on list "A". These dental codes are only billable for adults when provided with services to treat trauma or when the absence of dental treatment would adversely affect the recipient's preexisting medical condidition.

D0999	D2915	D3220	D3425	D4381	J0550
D1110	D2920	D3221	D3426	D4910	J0560
D1204	D2930	D3230	D3430	D4999	J0570
D2140	D2931	D3240	D3450	D5899	J0580
D2150	D2932	D3310	D3910	D6930	J0692
D2160	D2933	D3320	D3999	D6999	J0702
D2161	D2934	D3330	D4210	D7111	J0704
D2330	D2940	D3331	D4211	D7140	J1100
D2331	D2950	D3332	D4240	D7210	J1720
D2332	D2951	D3333	D4245	D7220	J2175
D2335	D2952	D3346	D4260	D7230	J2250
D2390	D2953	D3347	D4261	D7240	J2270
D2391	D2954	D3348	D4265	D7241	J2510
D2392	D2955	D3351	D4275	D7250	J2550
D2393	D2957	D3352	D4276	J0120	J3000
D2394	D2999	D3353	D4320	J0290	J3070
D2799	D3110	D3410	D4321	J0530	J3360
D2910	D3120	D3421	D4355	J0540	J3410

The recipient record must include documentation to substantiate services billed are related to trauma or other medical condition and must be provided to the state upon request.

Please refer to Section 13 of the Medicaid *Dental Provider's Manual* and the Dental Appendix for comprehensive coverage of dental benefits and limitations, as well as covered procedure codes, available on the Internet at www.dss.mo.gov/dms.